OFFICIAL INFORMATIONCONFIDENTIAL**EVIDENCE CODE SECTION 1040**
INTRADEPARTMENTAL CORRESPONDENCE

DATE: June 4, 2020

TO: Honorable Board of Police Commissioners

FROM: Inspector General

SUBJECT: IN-CUSTODY DEATH 031-19 FOR 6/9/20 CLOSED-SESSION AGENDA

Division	Date	Time	Duty-On (X) Off ()	Uniform-Yes (X) No ()
Central	7/14/19	5:00 p.m.		

Officer(s) Involved in Use of Force **Length of Service**

Not Applicable.

Total Involved Officer(s)

1 x Sgt. II
2 x Det. II
6 x PO II
4 x DO

Suspect	Deceased (X)	Wounded ()	Non-Hit ()

Leonard David Baca: Male Hispanic, 57 years old.

COP Recommendations

Tactics – Does Not Apply (No "substantially involved" personnel).
Drawing/Exhibiting – Does Not Apply.
Lethal Use of Force – Does Not Apply.

IG Recommendations

Tactics – Does Not Apply.
Drawing/Exhibiting – Does Not Apply.
Lethal Use of Force – Does Not Apply.

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INVESTIGATION

Synopsis

On Friday, July 12, 2019, at 1600 hours, officers assigned to the Central Area Narcotic Enforcement Detail (NED) were monitoring the area of San Pedro Street and 4th Street for narcotics activity. The officers observed Leonard Baca involved in a narcotics transaction. This information was broadcast to uniformed officers who detained Baca. Baca was searched and heroin was located in his shoe. Baca was subsequently placed under arrest for California Health and Safety Code section 11350(a), Possession of Narcotics and was booked at the Los Angeles Police Department (LAPD) Metropolitan Jail Section (MJS) later that evening.

On July 14, 2019, at 1701 hours, Baca was found, unconscious, inside of his cell. Jail personnel performed Cardiopulmonary Resuscitation (CPR) until the Los Angeles Fire Department (LAFD) arrived. Paramedics attempted lifesaving measures before determining that Baca was deceased at 1729 hours.

Annotated Force Investigation Division (FID) Incident Summary[1]

On Friday, July 12, 2019, at 1600 hours, Central Area NED, plainclothes Police Officers II, Adolfo Pacheco, Serial No. 38464, Unit 1N2, and Michael Mann, Serial No. 40912, Unit 1N3, were in the area of 4th Street and San Pedro Street conducting narcotics enforcement activities.

Officers Mann and Pacheco observed Jacob Flores, a person they believed to be a narcotics dealer, standing on the west side of San Pedro Street, north of 4th Street. The officers established an observation post and began watching Flores. Moments later, Officer Pacheco observed a male, later identified as Leonard Baca, walk up to Flores and converse with him.[2] During the conversation, Baca handed Flores an unknown amount of U.S. Currency. Flores accepted the currency before leaning down, manipulating his left shoe and handing Baca a small dark substance. Baca accepted the substance and wrapped it in a piece of white plastic before leaning down to tie his right shoe. Seconds later, Baca stood up and walked north along the west sidewalk of San Pedro Street toward Boyd Street.

[1] The Incident Summary presented here is reproduced from FID's report regarding this case, and is supplemented with annotations by the OIG. All OIG annotations are referenced as an "OIG Note." All other references and citations in the reproduced FID Incident Summary (e.g., Investigators' Notes or Addenda Items) are reproduced directly from FID's report. Unless otherwise stated, all information provided in OIG annotations is derived from FID's investigation of this incident.

[2] Baca, male, Hispanic, 5 feet 6 inches, 146 pounds, 57 years of age.

After watching the interaction between the two men, Officer Pacheco formed the belief that Baca purchased heroin from Flores and broadcast this information to Central Area uniformed Police Officers II Chad Heistermann, Serial No. 40775, and Erik Haskell, Serial No. 41440, who were waiting nearby.

At 1612 hours, after receiving Officer Pacheco's radio broadcast, Officers Heistermann and Haskell observed Baca walking north along the west sidewalk of San Pedro Street at Boyd Street. Officers Haskell and Heistermann approached Baca and verbally directed him to the southwest corner of the intersection. Baca complied and was handcuffed without incident. Officer Heistermann searched Baca and located a brown, tar-like substance resembling heroin in his right shoe; the substance was wrapped in a piece of white plastic. Officer Heistermann recovered the item and placed Baca under arrest for a violation of Health and Safety Code section 11350(a), Possession of Narcotics.

At 1616 hours, Officers Haskell and Heistermann placed Baca in the right rear passenger seat of their police vehicle.[3] Officers Haskell and Heistermann waited with Baca in the vehicle, while other members of the NED detained and arrested Flores. During that investigation, Alexandra Lopez was also arrested and placed in the left rear seat of the same police vehicle. At 1658 hours, Officers Haskell and Heistermann drove Baca and Lopez to the Central Community Police Station, hereafter referred to as Central Station, for processing (Addendum No. 1).

At Central Station, Baca was brought before the Central Patrol Division Watch Commander Sergeant II James Sterling, Serial No. 35950, for an intake interview. At 1707 hours, Sergeant Sterling completed the Adult Detention Log and pre-booking inspection. When asked, Baca denied having any complaints of injury or illness. Immediately thereafter, Baca was seated on the arrestee detention bench inside the Central Station report writing room (Addendum No. 2).

At 1900 hours, Officer Mann completed an Arrestee Medical Screening Form. When questioned, Baca advised he did not have any injuries or require medical attention (Addendum No. 3).

> **Note**: Force Investigation Division investigators reviewed the Arrestee Medical Screening Form and observed a notation indicating that Baca had open wounds on his right leg. When interviewed, Officer Mann stated that he did not observe any injuries on Baca. The source of the notation is unknown.

[3] The officers' police vehicle was a marked black and white Ford Explorer equipped with DICVS, Shop No. 81375.

> At 1956 hours, Central Area NED Detectives II Thomas Penson, Serial No. 30488, and Jorge Trejo, Serial No. 34438, walked Baca and Flores out of Central Station and transported them to MJS for booking.[4]

At 2006 hours, Detectives Penson and Trejo entered MJS with Baca and Flores and began the "Drop and Go" booking process.[5] Detective Penson completed a strip search of Baca. He did not locate any additional contraband or observe any signs of injury or medical distress. After the search, Detective Trejo walked Baca to cell No. 1B08, where he was temporarily housed, while jail personnel finalized his booking paperwork. Detectives Penson and Trejo then left MJS and returned to Central Station to complete reports (Addendum No. 4).

On July 13, 2019, at 0318 hours, Baca met with Medical Services Division (MSD) Registered Nurse (RN) Maristela Deguia and Physician Assistant (PA) Latonya Hitchcock in regard to the pre-existing wounds on his right leg. Baca told the medical staff he was a heroin user and was experiencing withdrawal symptoms. Physician Assistant Hitchcock advised FID investigators that she initially gave Baca Clonidine, to lower his blood pressure, and Methocarbamol, to ease his muscle cramps. After assessing Baca, PA Hitchcock prescribed four additional medications and placed him on the "Q4 Protocol" (Addendum No. 5).[6] [7]

At 0508 hours, Baca was placed in the South-D housing module, where he was housed with seven to 23 other inmates over the course of the next 26 hours.[8] During that time

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[4] Once Baca arrived at MJS, his movement throughout the facility was captured on security video cameras. There were two security video systems installed at MJS, each with its own proprietary viewing software. The Verint system consisted of approximately 198 cameras that were installed in common areas, hallways, and processing sections of the facility. The Genetec system consisted of approximately 167 cameras that were installed inside the housing modules. The systems record at a variable rate of 2-15 frames per second. Unless otherwise noted, all times were derived from MJS' Genetec security video system. The time on both security video systems were determined to be two minutes behind actual time. As such, the times listed in this report were adjusted to reflect the actual time.

[5] Drop and Go Booking is a program conducted by CSD jail personnel that allows the arresting officers to expeditiously return to the field. Jail personnel take custody of arrestees from the arresting/transporting officers after the arrestee is screened by a Drop and Go officer.

[6] The additional medications prescribed during his stay at MJS were: Tylenol, a pain reliever, Imodium, an anti-diarrheal, Bentyl, a medication for stomach cramping, and Compazine, an anti-nausea drug.

[7] The Q4 Protocol is an opiate withdrawal protocol that requires nurses to check on inmates every four hours and to provide them with prescribed medication as needed. Nurses check for overall alertness and symptoms such as diarrhea, vomiting and dehydration.

[8] The South-D housing module is an open-bay, two-tiered, general population housing module, designed to hold up to 33 inmates. The module consists of bunkbeds on the upper and lower levels, a common area and bathroom facilities.

period, the South-D module was the subject of 53 Title 15 safety checks (Addendum No. 6).[9]

On July 13, 2019, at approximately 1731 hours, RN Eric Smith was assigned to perform the Q4 checks on the South-D housing module.[10] According to RN Smith, Baca did not come to the module's door when he called for him at the 0900 and 1300-hour Q4 checks. On his third check, RN Smith asked Custody Services Division (CSD) Police Officer II Gi Dam Lee, Serial No. 42942, to enter the module and bring Baca to the module door. According to RN Smith, when Officer Lee entered the module, he located Baca in a bunk and told him that the nurse wanted to see him; however, Baca declined. Nurse Smith left the module since Baca refused to meet with him.[11]

When interviewed, Officer Lee advised that upon entering the module, he located Baca and observed him to be "*okay*." Baca told Officer Lee he did not need to see a doctor or need any other services. Officer Lee conveyed this information to RN Smith, who advised Officer Lee that Baca could remain in the module.

On July 14, 2019, at 0740 hours, Officer Lee and CSD Detention Officers (DOs) Gabriel Sanchez, Serial No. N5776, and Eric Ramirez, Serial No. N5054, conducted a start of watch inspection of the South-D housing module to account for each inmate. According to DO Sanchez, during the inspection he found Baca lying on the floor and asked him if he was okay. Baca told him that he was having trouble breathing. Upon contacting Baca, DOs Sanchez, Ramirez and Officer Lee each observed a small amount of blood on Baca's lips and mouth.

At 0744 hours, the officers left the module to obtain a wheelchair. When they returned approximately four minutes later, they assisted Baca into the chair and wheeled him to the dispensary.

At 0750 hours, RN Jamie McVicker examined Baca at the dispensary. According to RN McVicker, Baca advised that he was experiencing abdominal pain and nausea, but that he had not vomited. Nurse McVicker was aware that Baca was withdrawing from

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[9] The California Code of Regulations, Title 15, Section 1027, requires hourly safety checks of inmates. A safety check is a direct, visual observation performed at random intervals to provide for the health and welfare of inmates. Safety checks shall be done in person. Audio/video monitoring may supplement but not substitute for direct visual observation. In addition to the hourly safety checks mandated by the State of California, the LAPD Jail Operations Manual mandates an additional check every hour, for a total of two checks per hour. Detention personnel conducting safety checks shall look at an inmate for signs of life (e.g. breathing, talking, movement) and obvious signs of distress (e.g. bleeding, trauma, visible injury, choking, or difficulty breathing). The completed checks are documented on CSD Observation Records (LAPD form 06.17.00) that are kept near the entrance to the area being checked.

[10] As a part of this investigation, FID investigators requested Baca's medical records, including all Q4 logs, from MSD. Medical Services Division refused to provide the records, citing the Health Insurance Portability and Accountability Act (HIPAA).

[11] Medical staff must be escorted at all times throughout the jail facility and are not authorized to enter housing modules.

opiates and attributed his symptoms to the withdrawal process. Nurse McVicker administered Bentyl to treat Baca's stomach cramps, Compazine to treat nausea, and Methocarbamol, a muscle relaxer. After administering the medication, RN McVicker cleared Baca to return to the South-D housing module.

At approximately 0800 hours, DO Ramirez directed Officer Lee and DO Sanchez to place Baca into cell South-B-102.

> ***OIG Note No. 1:*** *As stated by DO Ramirez, "102 is a segregation cell. The reason for me deciding to place him there is because in general population if he's weaker, he's not getting up, I don't want him being messed with by other people. It's -- it is -- it is a heavy populated cell. It's a 32-man cell. Besides that, when it's time for chow, when it's time for them to eat, they're required to come up to the door and show us a wristband. If he's feeling that sick it's likely that he won't come up and we'll have to go find him in the cell and that -- that deters us from doing other things that we have to do and slows down the whole process."*[12]

The South-B housing module is comprised of 32 single-person cells on two levels. Each of these cells is equipped with a bed, sink, toilet and security camera. Baca remained in this cell for 16 hours and 47 minutes, and was the subject of 17 Title 15 safety checks (Addendum No. 7) (Issues and Concerns No. 1).

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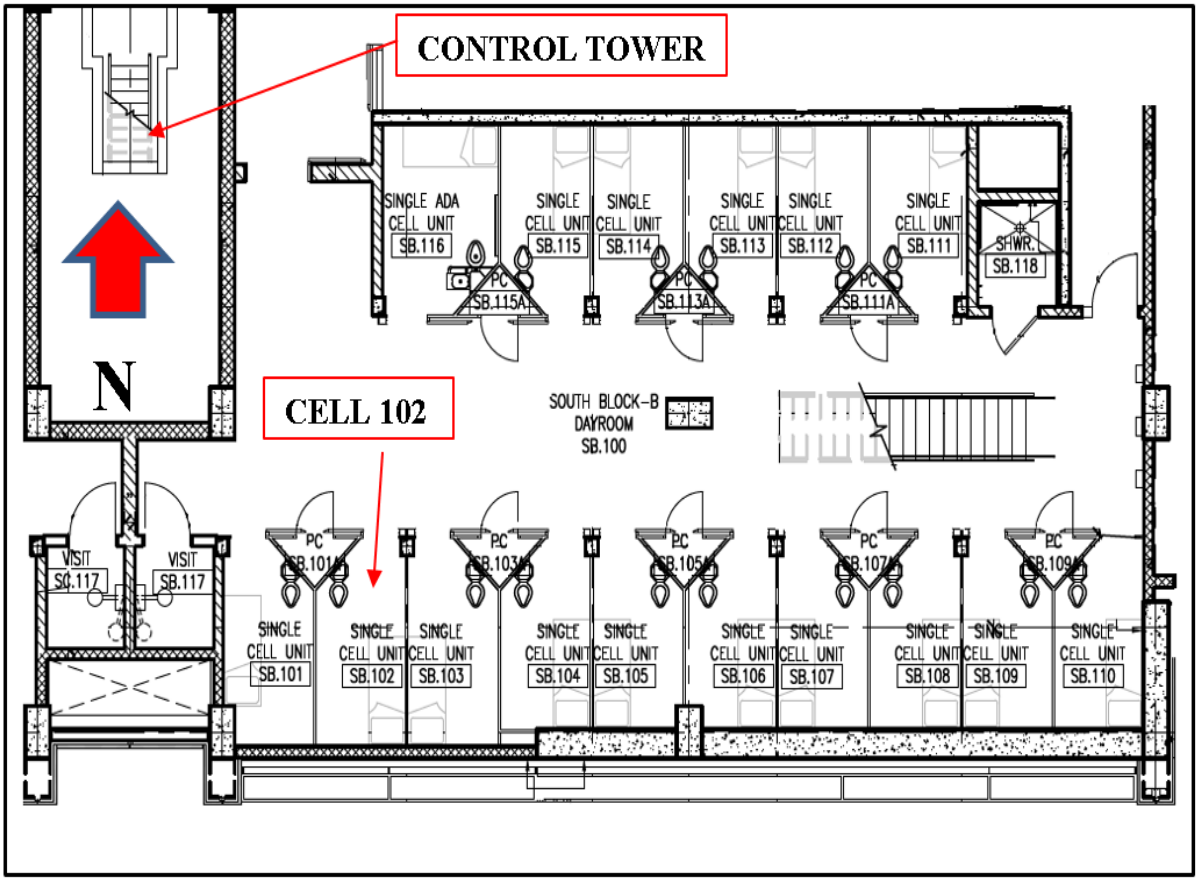
[12] Ramirez, Page 14, Lines 14-24.



Schematic of the South-B housing module, first level

At 1310 hours, MSD RN Juana Gonzales performed Q4 checks in the South-B housing module. According to RN Gonzales, she stopped in front of Baca's cell door, observed him lying in his bunk and noticed he had not eaten his lunch. After being encouraged by RN Gonzales to eat, Baca stood up, walked to the door and picked up his lunch from the cell port.[13] Nurse Gonzales asked Baca if he was okay. Baca responded "yeah" before taking his food and returning to the bed. According to RN Gonzales, Baca appeared to be tired, which was a side effect consistent with the medications he had received earlier in the day.

[13] A cell port (5 inches in height by 16 ½ inches in width) that allowed food, medicine, and other small items to be passed through, was located between the upper and lower windows of the door.

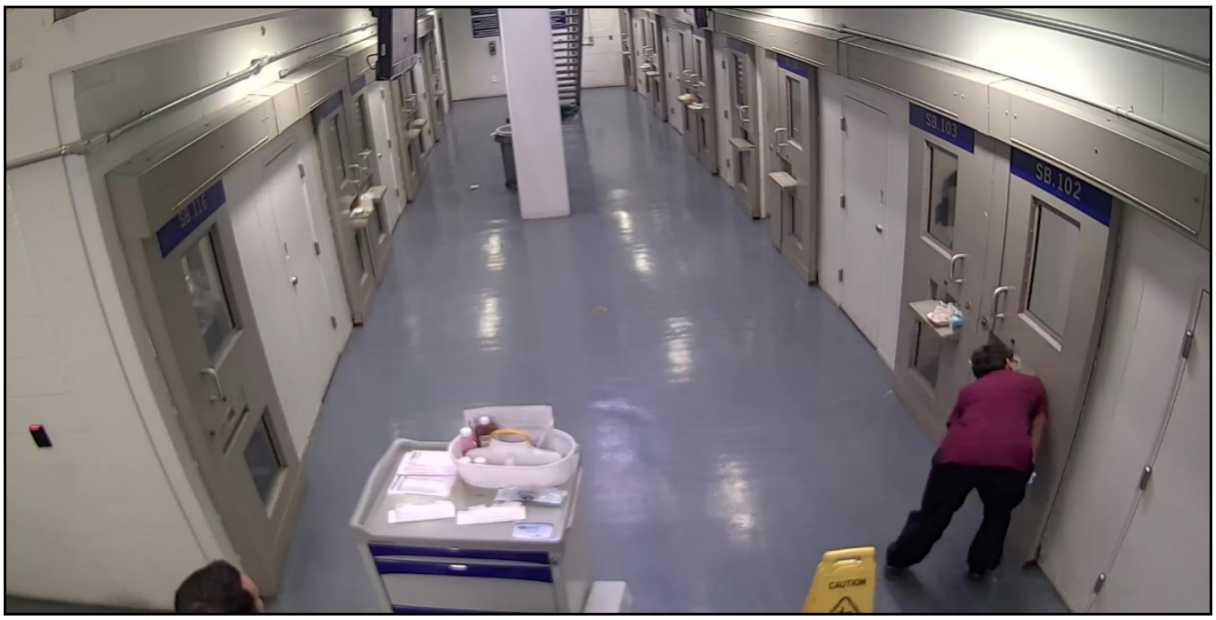


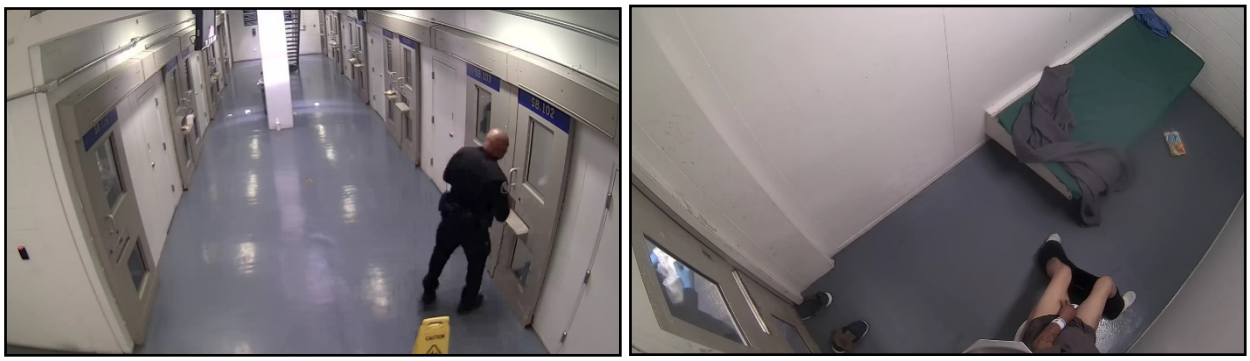
Image obtained from MJS security video depicting RN Gonzales performing the Q4 check.

At 1611 hours, DO Kenneth Mason, Serial No. N5989, entered the South-B housing module to perform Title 15 safety checks. Prior to entering the module, DO Mason documented the check by signing a CSD Observation Record. Detention Officer Mason stopped in front of Baca's door, looked through the window and observed Baca sitting on the toilet. According to DO Mason, Baca's head was tilted to the right and his chest was moving; he believed Baca was sleeping.

> ***OIG Note No. 2****: According to DO Mason, "He was fine. I stopped by the door, looked at him. He was sitting on the stool and his chest was moving. He was breathing. I didn't see anything alarm (sic) to me to go into that cell."*[14]

Detention Officer Mason stated he did not bang on the window or enter the cell, because it was common for arrestees to fall asleep while on the toilet. After completing the Title 15 safety check of Baca's cell, DO Mason completed additional Title 15 safety checks before leaving the module.

[14] Mason, Page 9, Lines 14-18.



Images obtained from MJS security video depicting DO Mason performing the safety check at 1611 hours.

At 1632 hours, DO Mason entered the South-B housing module to perform Title 15 safety checks. Prior to entering the module, DO Mason again signed the CSD Observation Record. According to Mason, before he started the checks, DO Ramirez contacted him via intercom and asked him to go to the second level and escort an inmate, later identified as Miguel Williams, out of the module so that he could be transferred to Twin Towers. Detention Officer Mason suspended his Title 15 safety checks, went to the second level, located Williams and escorted him down the stairs, passing Baca's cell at 1637 hours. According to DO Mason, as he passed cell South-B-102, he could see Baca in his peripheral vision and could tell he was still seated on the toilet, but he did not stop and look directly into the cell, because his focus was on escorting Williams. Detention Officer Mason left the South-B housing module without performing any additional Title 15 safety checks, or notifying other staff members that the checks were not completed.

Image (left) from MJS security video depicting DO Mason escorting Williams past Baca's cell.

Image (right) from MJS security video depicting the interior perspective for the same period of time.

Force Investigation Division investigators reviewed CSD Observation Records documenting the Title 15 safety checks done in the South-B housing module on July 14, 2019. These records were compared to the MJS security video and it was determined that all prior checks were completed in accordance with Department policy.

At 1701 hours, Officer Lee was conducting Title 15 safety checks in the South-B housing module. When Officer Lee looked into cell 102, he observed Baca sitting on the toilet with the right side of his body leaning against the west wall. Officer Lee attempted to get Baca's attention by knocking on the window with his hand. Officer Lee noticed Baca was drooling and believed he was unconscious or deceased. Officer Lee used his radio to request that DO Ramirez, who was working in the control tower, open Baca's cell door.

Once the door was open, Officer Lee stepped into the cell alone and attempted to rouse Baca by tapping Baca's chest and left elbow with his left hand. When he did not receive a response, Officer Lee gripped Baca's left forearm and gently shook it. Over the intercom, DO Ramirez asked him if Baca was okay. Using first his police radio and then the cell's intercom, he advised DO Ramirez that he did not think Baca was breathing. Officer Lee then checked Baca's left wrist for a pulse. After failing to locate a pulse, he moved Baca to the floor of the cell and placed him in a supine position (Issues and Concerns No. 3).

Image obtained from MJS security video depicting Officer Lee making initial contact with Baca.

Upon hearing Officer Lee's request to open the cell door, DO Ramirez began monitoring the cell's security camera; he also activated the intercom so he could monitor the audio inside the cell and communicate with Officer Lee. According to DO Ramirez, he observed Officer Lee enter the cell and attempt to wake Baca. Detention Officer Ramirez asked Officer Lee if Baca was okay, and Officer Lee advised that Baca was

unresponsive and did not have a pulse. Detention Officer Ramirez alerted DOs Mason and Sanchez to the situation before leaving the control tower to assist Officer Lee. Detention Officer Sanchez left with DO Ramirez, while DO Mason remained behind to staff the control tower. After leaving the tower, DOs Ramirez and Sanchez encountered RN Gonzales, who was conducting Q4 checks in the area with CSD Police Officer II Kasey Campbell, Serial No. 43004. The group joined Officer Lee at 1703 hours.

Nurse Gonzales assisted Officer Lee with moving Baca outside of the cell, where they immediately initiated CPR. Officer Lee performed chest compressions, while RN Gonzales held Baca's head and maintained an open airway. According to DO Ramirez, he simultaneously used his police radio to broadcast, "*We have a man down in South Boy 102. The arrestee is unresponsive. We're starting CPR. I need additional personnel and medical staff.*"[15] [16]

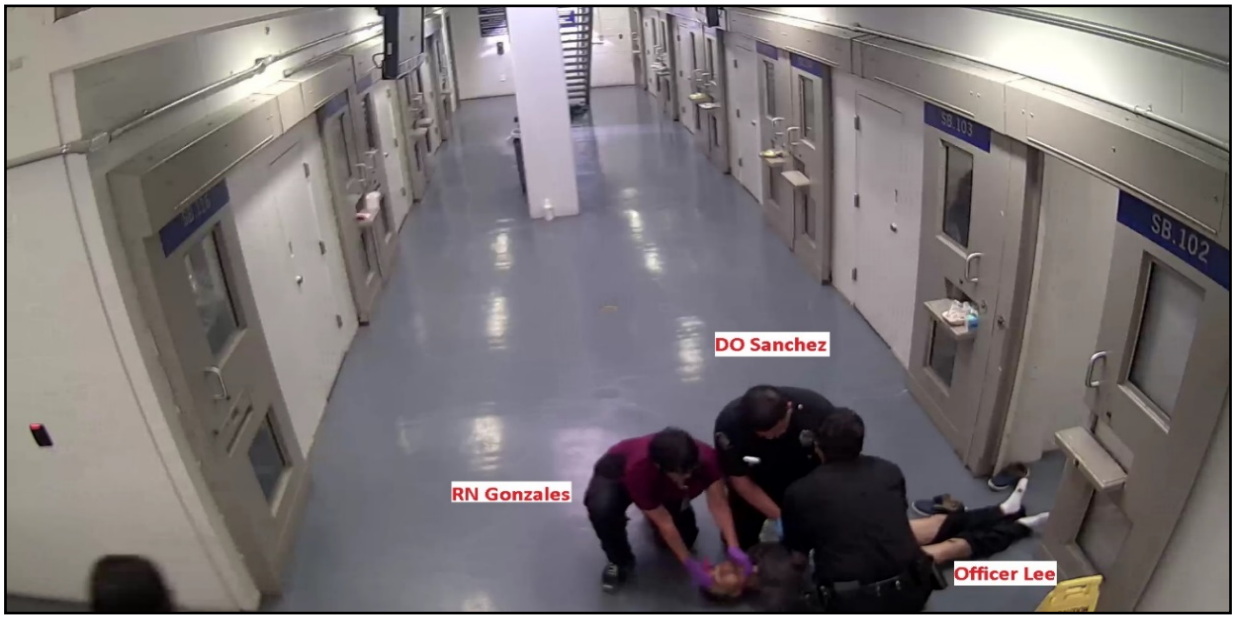


Image obtained from MJS security video depicting jail staff beginning CPR on Baca at 1703 hours.

In response to DO Ramirez's broadcast, MJS staff contacted the LAFD Metropolitan Fire Communications at 1703 hours. The LAFD dispatched Engine 4 and Rescue Ambulance 209.

[15] Ramirez, Page 17, Lines 10-12.

[16] The broadcast was made over Channel 248, a non-recorded frequency that is assigned to MJS. Force Investigation Division investigators contacted Communications Division (CD) and were informed that Channel 248 is not monitored by CD.

After making the “man down” broadcast, DO Ramirez obtained an Automated External Defibrillator (AED) and placed the defibrillator pads on Baca’s chest and torso.[17] Although the defibrillator pads were applied to Baca and the AED was powered on, a shock was not administered, because the AED did not detect a shockable heart rhythm.[18]

At 1705 hours, MSD Doctor Roland Lee arrived with RNs Eric Smith and Jaime McVicker; all three were in the dispensary at the time the “man down” broadcast was initiated. Prior to leaving the dispensary, RN Smith obtained a bag of emergency medical supplies and brought it with him to the South-B housing module. Doctor Lee oversaw the lifesaving efforts, while RN Smith began ventilating Baca with a bag valve mask and RN McVicker prepared to administer an intravenous line.

Image obtained from MJS security video depicting jail staff performing CPR on Baca at 1704 hours.

[17] The Automated External Defibrillator is an external defibrillator capable of cardiac rhythm analysis, which can deliver an electric shock to a cardiac arrest victim.

[18] The AED was recovered by FID investigators and the information stored on it was downloaded by the LAFD. A review of that information determined that the device was in working order. A shock was never delivered because the AED determined Baca was pulseless.

During this incident, CPR was provided continuously until the arrival of LAFD. Officer Lee, RN Gonzales, DO Sanchez and DO Yumiko Bonilla, Serial No. N4955, provided chest compressions, while RNs Smith, McVicker and Gonzales provided ventilations.

At 1717 hours, the LAFD personnel assigned to Engine 4 entered the South-B housing module and assumed care of Baca. Approximately 60 seconds later, FFPs Orrante and Oransky joined the Engine 4 personnel. After attempting life saving measures, FFPs Orrante and Oransky determined Baca deceased at 1729 hours (Addendum No. 8).

At 1753 hours, CSD Assistant Commanding Officer, Captain II Gary Newton, Serial No. 47010, notified the Department Operations Center (DOC) of Baca's death (Addendum No. 9).

Force Investigation Division Detective II Douglas Johnson, Serial No. 37738, reviewed all documents and circumstances surrounding the separation, monitoring and admonition to officers and DOs not to discuss the incident prior to being interviewed by FID investigators (Addendum No. 10) (Issues and Concerns No. 4).

Scene Description

This incident occurred inside of the LAPD MJS, located at 180 North Los Angeles Street. The jail facility was well lit with overhead lights throughout the interior. Baca was housed on the lower level of the South-B housing module inside of cell 102. Each of the 16, single-person, cells on the lower level of this module were similarly configured with a bed, sink, and toilet. Cell 102 measured approximately 11 feet long by 6 feet wide and had a security camera mounted on the north wall, near the ceiling. The door to this cell contained two windows, one on the upper portion of the door (21 ¾ inches in height by 13 inches in width) and one on the lower portion (14 ¾ inches in height by 13 inches in width). A cell port (5 inches in height by 16 ½ inches in width) that allowed food, medicine, and other small items to be passed through, was located between the upper and lower windows of the door.

Canvas for Witnesses

On July 14, 2019, FID investigators conducted a canvass of the South-B housing module. The statements of all witnesses were transcribed and are included as a part of this report.

Eric Gallardo was housed inside of cell 106. When interviewed, he told investigators he was asleep when he heard someone screaming for help over a period of one or two hours. Gallardo estimated the screaming occurred at an unknown time on Saturday, July 13, 2019, and believed it was coming from someone on the second level of the module.

> **Note:** Baca was housed in cell 102, which was located four cells away from Gallardo on the first level of the housing module.

Michael Duvall was housed inside of cell 113. When interviewed, he told investigators he heard someone "*in pain*" who was "*wailing for help*" and "*hacking in the bathroom*." Duvall believed the person was experiencing "*labored breathing*." Duvall estimated he initially heard the person at approximately 0500 hours on Saturday, July 13, 2019. Duvall believed the sounds were coming from cell 104 or 105.

Timothy Cathey was housed inside of cell 103. When interviewed, he told investigators he heard "*weird yelling*" for approximately two days, but did not know if it was coming from Baca's cell.

> **Note**: A review of the MJS security video confirmed that Baca was first housed in the South-B housing module at 0801 hours on Sunday July 14, 2019. He remained in the module from 0801 hours until his discovery by Officer Lee at 1701 hours. As such, Baca was not present in the module on Saturday when the inmates reported hearing the previously described yelling.

Andre Dunlap was housed inside of cell 108. When interviewed, he told investigators he heard an older man yelling for help. Dunlap estimated the yelling occurred three or four minutes before the DOs announced that there was a "*man down*."

> **Note**: A review of the MJS security video determined that Baca was seated on the toilet from 1608 hours until the time that he was discovered by Officer Lee. Baca's last observed movement was at 1613 hours [48 minutes before he was discovered].

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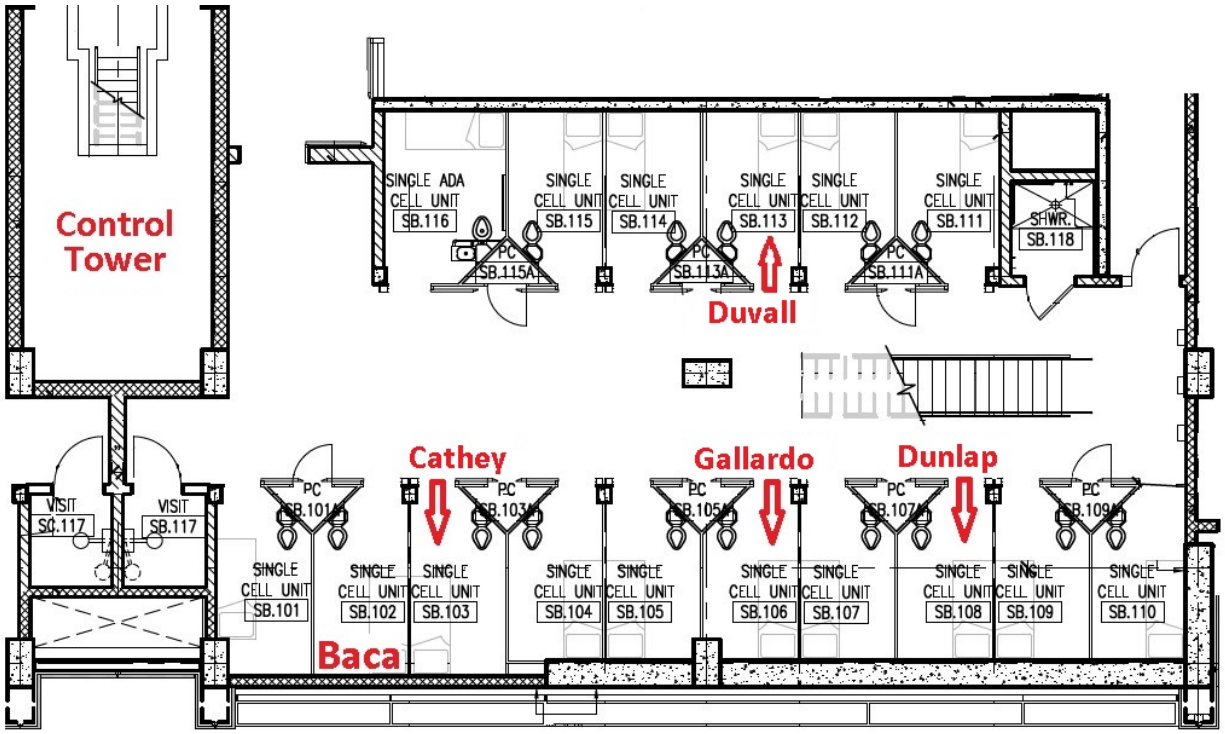

Diagram of inmate witness locations

Force Investigation Division investigators determined that Custodian Edward Dominguez was cleaning the inside of the South-B housing module between 1641:30 hours and 1644:15 hours. When interviewed, Custodian Dominguez told FID investigators that he did not see anything out of the ordinary and that everything seemed quiet and normal. Custodian Dominguez stated that he did not hear any inmates yelling or asking for assistance.

As a part of this investigation, FID investigators reviewed video footage that covered the inside of Baca's cell from the point he entered until he was removed. Based on a review of the footage, it appears Baca did not make any attempt to use the intercom system or otherwise summon assistance.

Subject Information

Leonard David Baca was a male Hispanic, with black hair and brown eyes. At the time of the incident, he was 5 feet and 6 inches tall, weighed 146 pounds, and had a date of birth of January 27, 1962. Baca was identified by CII No. A06451416.

Baca had no prior contact with the Mental Evaluation Unit and was not on parole or probation at the time of his arrest. Baca

was a documented member of the Primera Flats criminal street gang with the moniker "Lil Leonard."

Baca had thirteen criminal convictions dating back to 1982, including: Carrying a Concealed Firearm in a Vehicle, Assault with a Firearm, Robbery, Inflicting Corporal Injury on a Spouse or Cohabitant, and six narcotic/alcohol related offenses. (Addendum No. 11).

Injuries

At 1701 hours, Officer Lee discovered Baca unresponsive in his cell and requested assistance from other staff members. Jail and dispensary personnel removed Baca from his cell, initiated CPR and contacted the LAFD for assistance. During this incident, jail and dispensary staff continuously provided CPR under the supervision of Doctor Lee.

At 1717 hours, Engine 4, staffed by Captain Morda, FFP Tamrazian, FFs Johnson and Magana entered the South-B housing module and assumed care of Baca. Approximately 60 seconds later, the engine crew was joined by FFPs Orrante and Oransky from RA 209. After attempting life saving measures, FFPs Orrante and Oransky determined that Baca was deceased at 1729 hours.

Evidence

There were six items of evidence booked in conjunction with this investigation (DR No. 1901-18397) (Addendum No. 12).

On July 15, 2019, FID Sergeant II Jess Falk, Serial No. 38231, utilized a single Buccal swab to collect a sample of red liquid from the floor inside of Baca's cell.[19] The swab (Item No. 1) was packaged and booked at Central Property Section.

On October 08, 2019, Detective Johnson visited the Los Angeles County Coroner's office and took custody of the following items: Coroner's kit (Item No. 2), fingernail kit (Item No. 3), hair kit (Item No. 4), blood stain card (Item No. 5) and a projectile kit (Item No. 6).[20] The items were packaged and booked at Central Property Section.

On January 31, 2020, Forensic Science Division, Criminalist II Jose Gonzalez, Serial No. N2501, finalized a laboratory report documenting the analysis of the brown, tar-like, substance recovered from Baca's shoe at the time of his arrest. According to the report, the material was determined to be heroin (Addendum No. 13).

[19] The swab of the red substance was not analyzed in light of the Coroner's findings. The swab will be held at Property Division should future analysis be necessary.

[20] During the autopsy, a pre-existing, lead projectile was removed from the soft tissue in Baca's back. According to Doctor Parks, the projectile appeared to be old and was not related to this incident.

Coroner's Investigation

Coroner's Response

On July 14, 2019, at 1946 hours, FID Detective II Ubaldo Zesati, Serial No. 30078, reported Baca's death to the County of Los Angeles Department of Medical Examiner-Coroner. Baca's death was subsequently assigned Coroner Case No. 2019-05293.

At 2215 hours, Coroner's Investigator Lianna Darabedyan arrived at MJS. She was later joined by Coroner's Attendant John Green who, at 2300 hours, transported Baca's remains to the Forensic Science Center.

Autopsy

On July 16, 2019, at 0900 hours, Senior Deputy Medical Examiner Ajay Paschal, and Associate Deputy Medical Examiner Robyn Parks, performed a post-mortem examination of Baca's remains. Force Investigation Division Detective III Anthony Rheault, Serial No. 33961, Detective II Timo Illig, Serial No. 36893, and Detective Johnson were present during the examination.

On September 29, 2019, Doctor Paschal classified the manner of death as accidental and ascribed the cause to an upper gastrointestinal hemorrhage, a perforated gastric ulcer, gastric varices[21] and portal hypertension arising from cirrhosis. Methamphetamine toxicity and hypertensive cardiovascular disease were also determined to be other contributing factors in Baca's death. Doctor Paschal's findings were documented in Autopsy Report No. 2019-05293 (Addendum No. 14).

Toxicology

On September 06, 2019, a Laboratory Analysis Summary Report was approved by the Los Angeles County Department of Coroner, Supervising Criminalist Sarah Buxton de Quintana. The analysis results documented that Baca had .08 ug/mL of methamphetamine in a blood sample that was taken from inside of his femoral artery and .16 ug/mL of methamphetamine, and .03 ug/mL of amphetamine, in a blood sample that was taken from his heart.

[21] Gastric varices are abnormal, enlarged veins in the stomach.

Visual Documentation

Digital In-Car Video System (DICVS)

Officers Haskell and Heistermann's police vehicle, Shop No. 81375, was equipped with a DICVS. The officers activated the system upon placing Baca in the rear passenger compartment. The system continuously recorded until the officers parked at Central Station and Baca exited the vehicle.

Body Worn Video (BWV)

Officers Haskell and Heistermann were equipped with BWV cameras. The cameras captured their initial detention, arrest, and transport of Baca. Their BWV continuously recorded until they were parked at Central Station. Baca was later transported to MJS by detectives who were not equipped with BWV.

> **Note**: A review of Officer Haskell and Heistermann's BWVs determined that Officer Heistermann had a delayed activation of approximately 29 seconds and Officer Haskell had a delayed activation of approximately three minutes and 22 seconds.

Social Media

Police Officer II John Sewell, Serial No. 36614, assigned to FID's Cyber Unit, monitored social media sites, from the date of the incident until the submission of this investigative report. No additional evidence, information or witnesses were identified.

Other Department Video

Central Station was equipped with a security video system that recorded footage of Baca during his time in the station. Force Investigation Division personnel downloaded all applicable video footage from the point Baca entered Central Station to the point he left for booking at MJS. The related video footage was vaulted at the Electronics Section of TID under Control No. A751476.

The MJS is equipped with approximately 365 cameras that are connected to two closed circuit video systems (Genetec and Verint). Each of these systems captured footage of Baca during his stay in the facility. Force Investigation Division personnel downloaded all applicable video footage from the point Baca entered MJS until he was determined deceased by LAFD. The related video footage was vaulted at the Electronics Section of TID under Control No. A751476.

Outside Video

None.

Photographs

Technical Investigation Division Photographer III Gary Raives, Serial No. V9103, responded to MJS on the night of the incident and photographed the scene, associated evidence and Baca's remains. The photographs were stored, at TID under Control No. 770046.

Notifications

At 1753 hours, the DOC was notified of this incident. The details of the subsequent notifications are attached to this report.

Personnel at Scene

At 1900 hours, Sergeant Falk, was the first FID representative to arrive at scene. Crime scene logs documenting additional personnel at the location are stored in the FID casebook.

Communications

A copy of the CD computer-generated Incident Recall printout associated with this occurrence, Incident No. 190714004047, is on file at FID. A digital recording of the Central Area Base Frequency at the time of this incident, is on file at CD. Copies were also retained in the FID casebook and are available for review.

The digitally recorded interviews of all sworn personnel and the civilian witnesses were stored in the LAPD Training Evaluation and Management System (TEAMS II) database.

Justice System Integrity Division

This case did not meet the criteria for presentation to the Justice System Integrity Division of the Los Angeles County District Attorney's Office.

Issues and Concerns

1. On July 14, 2019, DO Ramirez was assigned as a Lead Detention Officer (LDO) for the South housing modules. Lead Detention Officers are non-supervisory team leaders, who are tasked with overseeing the completion of jail logs and delegating assignments to other staff members. Jail Operations Manual, section 2/204.06, states that "Administrative segregation is to be authorized upon approval of a jail supervisor." Detention Officer Ramirez' status as a LDO did not authorize him to segregate Baca.

   In expressing his rational for segregating Baca, DO Ramirez indicated he believed Baca was in a weakened state. He expressed a concern that if Baca was placed in a general population cell, he could be "*messed with*" by other arrestees [up to 32]. He also took into consideration that if Baca was not feeling well, he might not be able to come to the cell door during mealtimes to show his wristband, as required.

This would then obligate jail personnel to go into the general population cell to find Baca, which would have slowed down their process. Detention Officer Ramirez also believed that Baca would be more comfortable in a segregated cell and that nursing and jail personnel would be able to communicate with him more efficiently than if he was in a general population cell.

2. On July 12, 2019, Miguel Williams was arrested for robbery by officers assigned to Central Patrol Division; he was later booked at MJS under Booking No. 5686323. At MJS, Detention Officer Mason did not handcuff Williams prior to escorting him alone. According to DO Mason, he did not recall Williams' booking charge, but believed, based on communication he received from DO Ramirez, that Williams was a non-violent offender, who was being transferred to Twin Towers for medical housing. When asked, DO Ramirez did not recall directing DO Mason to move Williams. Jail Operations Manual section 2/100, specifies that "All felony inmates and any inmate, who is believed to pose a threat, should be handcuffed and escorted by two officers when being moved to or from a housing unit."

3. Although Officer Lee broadcast for DO Ramirez to open Baca's cell door, he did not broadcast "Officer Needs Help" prior to entering the cell alone. Jail Operations Manual section 2/126, specifies that "If after assessing the situation, the detention employee decides to enter an occupied cell alone, the involved employee shall call for assistance prior to entering the cell. The request shall be for Officer Needs Help, followed by a brief explanation of the emergency, their intention to enter a cell and the cell number. Prior to entering the cell, the involved detention employee must receive acknowledgement of their request for backup."

4. The following is a list of additional issues that were identified during this investigation.

    - Investigators reviewed CSD Observation Logs for the South-B and South-D housing modules; the logs documented total inmate population and Title 15 safety checks for July 14, 2019. Upon reviewing the documents, investigators noted that the documented inmate population, on both forms, did not change at the point Baca was removed from one module and placed in the other.

    - On July 14, 2019, at 0900 hours, Nurse Gonzales appears to have been unaccompanied during her Q4 check of the South-B housing module. Jail Operations Manual section 2/214, specifies that "Custody Services Division personnel shall ensure that medical staff is escorted, without exception, when they conduct sick call in Custody Services Division."

    - The MJS is equipped with a digital system that is capable of tracking Title 15 safety checks. The system consists of card readers that are placed throughout the jail. Once an employee scans their identification card across the device, an electronic entry is made in an associated computer database known as

Symmetry Global. While it appears the system was utilized by various members of the MJS team, several members seemed to have a limited understanding of how, when and why the system was to be used. Investigators attempted to review written policy on the use of the Symmetry Global system, but it appears, at the time of this incident, none existed.

- Custody Services Division Sergeant I David Lopez, Serial No. 39711, told investigators that he had received no formal training on jail operations prior to his assignment at MJS. While it is clear that police officers receive jail training, it is unclear supervisory personnel do.

- When interviewed by FID investigators, Gallardo indicated that his intercom system was not functioning on the day of the incident. On January 21, 2020, Detective Johnson directed CSD DO Nicholas McDonald, Serial No. N5991, to test the intercom system in cell South-B-106. Upon testing the intercom, DO McDonald determined that it was not functional. Custody Services Division, Divisional Order No. 7, dated May 29,2019, says that "prior to placing an inmate into a segregation cell, the officer(s) shall visually inspect the cell for any contraband, general damage, vent coverage, camera obstruction or damage. Jail facilities with inmate intercoms shall perform an intercom check with their respective housing unit, ensuring the intercom operates."

Investigators' Notes

1. Throughout his interview, DO Mason mistakenly referred to DO Ramirez as DO Rodriguez. A check of MJS records determined there were no employees named Rodriguez working on the day of this incident.

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CHIEF OF POLICE REPORT[22]

Chief of Police Findings

- There was no Use of Force related to Baca's detention or arrest. The UOFRB determined, and the Chief concurred, that the actions of the involved Central Patrol Division and Custody Services Division personnel did not contribute to Baca's death; therefore, individual findings are not required.

Tactics – Does Not Apply (No "substantially involved" personnel).

Drawing/Exhibiting – Does Not Apply.

Lethal Use of Force – Does Not Apply.

Chief of Police Analysis

Detention

- Officers Pacheco and Mann observed Baca involved in a purchase of illegal narcotics and directed Officers Heistermann and Haskell to conduct an investigative stop on Baca. Officers Heistermann and Haskell detained Baca without incident. A brown, a tar-like substance resembling heroin, wrapped in white plastic, was recovered from Baca who was subsequently placed under arrest for the Possession of Narcotics. The officers' actions were appropriate and within Department policies and procedures.

  Captain T. Harrelson, Serial No. 32090, Commanding Officer, Central Area, conducted an analysis of the actions of the responding and involved officers. His analysis included a review of tactics, adherence to procedures, and coordination of resources. Captain Harrelson did not note any deviations from Department policy.

Tactical De-Escalation

- *Tactical de-escalation involves the use of techniques to reduce the intensity of an encounter with a suspect and enable an officer to have additional options to gain voluntary compliance or mitigate the need to use a higher level of force while maintaining control of the situation.*

  Tactical De-Escalation Techniques

  - ***P**lanning*
  - ***A**ssessment*
  - ***T**ime*
  - ***R**edeployment and/or Containment*
  - ***O**ther Resources*

[22] The information provided in this section summarizes the analysis and findings set forth in the Chief of Police's report for this case.

- ***L**ines of Communication (Use of Force - Tactics Directive No. 16, October 2016, Tactical De-Escalation Techniques)*

Tactical de-escalation does not require that an officer compromise his or her safety or increase the risk of physical harm to the public. De-escalation techniques should only be used when it is safe and prudent to do so.

In this case, the involved personnel were maintaining custody of the suspect at the time of this incident and were not engaged in any tactical operations. Therefore, the incident was not evaluated for Tactical De-escalation.

Command and Control

- *Command and Control is the use of active leadership to direct others while using available resources to coordinate a response, accomplish tasks and minimize risk. Command uses active leadership to establish order, provide stability and structure, set objectives and create conditions under which the function of control can be achieved with minimal risk. Control implements the plan of action while continuously assessing the situation, making necessary adjustments, managing resources, managing the scope of the incident (containment), and evaluating whether existing Department protocols apply to the incident.*

  Command and Control is a process where designated personnel use active leadership to command others while using available resources to accomplish tasks and minimize risk. Active leadership provides clear, concise, and unambiguous communication to develop and implement a plan, direct personnel and manage resources. The senior officer or any person on scene who has gained sufficient situational awareness shall initiate Command and Control and develop a plan of action. Command and Control will provide direction, help manage resources, and make it possible to achieve the desired outcome. Early considerations of PATROL will assist with the Command and Control process (Los Angeles Police Department, Training Bulletin, Volume XLVII Issue 4, July 2018).

  Detention Officer Erby heard the broadcast of a Man Down in South Pod and responded to B-block. Upon arrival, Detention Officer Erby began to monitor and control the incident. Detention Officer Erby observed that MJS personnel were already performing CPR on Baca without the need for his direction, so he canvassed for witnesses and directed available staff to remove the inmates that could directly view the incident. Detention Officer Erby also recognized the need to preserve the crime scene so he directed personnel to tape off the area. Detention Officer Erby also continually utilized department resources to ensure that an RA was enroute.

  The actions of Detention Officer Erby were consistent with Department training and met the Chief's expectations of a senior officer during a critical incident.

Sergeant Barnes heard the broadcast of a Man Down and began to monitor the incident via his radio and the live-feed video cameras located within the module. Sergeant Barnes observed MJS personnel providing medical attention to Baca and also heard several requests for an RA to respond to the location. Sergeant Barnes initiated a chronological log to document the incident. Hearing that Baca was unresponsive, Sergeant Barnes made telephonic notifications. Sergeant Barnes also ensured both the MJS and medical staff that were involved in the incident were separated and monitored until the arrival of FID investigators.

The actions of Sergeant Barnes were consistent with Department supervisory training and met the Chief's expectations of a Department supervisor during a critical incident.

General Training Update (GTU)

- Sergeant Barnes and Officer Lee attended a GTU on July 25, 2019. All mandatory topics were covered, including In-Custody Deaths.

Additional/Equipment

- **Incomplete Arrestee Medical Screening Form –** The investigation revealed that Officer Mann did not complete the Arrestee Medical Screening Form in its entirety. Officer Mann's actions resulted in unknown personnel completing the Arrestee Medical Screening Form inaccurately with a notation that Baca had an open wound on his leg. Officer Mann is reminded that the completion of the Arrestee Medical Screening Form in its entirety is essential in the processing of inmates. Captain Harrelson was advised of this issue. Captain Harrelson advised that this issue was addressed through informal training and the generation of a Supervisory Action Item (SAI). The Commanding Officer of Operations – Central Bureau (OCB) and the Director of the Office of Operations (OO) concurred with this action. As such, the Chief deemed no further action is necessary.

- **Administrative Segregation –** The FID investigation revealed that on July 14, 2019, at approximately 0800 hours, Detention Officer Ramirez directed Officer Lee and Detention Officer Sanchez to place Baca into South-B-102, a single occupant segregation cell. Detention Officer Ramirez was assigned as a Lead Detention Officer (LDO) for the South housing modules. Lead Detention Officers are non-supervisory team leaders, who are tasked with overseeing the completion of jail logs and delegating assignments to other staff members. Jail Operations Manual, section 2/204.06, states that "Administrative segregation is to be authorized upon approval of a jail supervisor." Detention Officer Ramirez' status as a LDO did not authorize him to place Baca in a segregation cell. Captain G. Newton, Serial No. 47010, Commanding Officer, CSD, was advised of this issue and addressed it through divisional training, the issuance of an Employee Comment Sheet, and the generation of a Supervisory Action Item (SAI). In addition to the corrective action for Detention Officer Ramirez, the subject of Administrative Segregation was briefed during all CSD roll calls for five consecutive days. The Commanding Officer of Administrative Services Bureau (ASB) and the Director of the Office of Support

Services (OSS) concurred with these actions.[23] As such, the Chief deemed no further action is necessary.

- **Unescorted Medical Staff –** The FID investigation identified that RN Gonzales was not escorted by jail staff for the July 14, 2019, 0900 hours, Q4 check. Jail Operations Manual section 2/214 requires that medial staff be escorted by jail personnel. Captain Newton was advised of this issue. Since medical staff personnel are not employees of the Police Department, but are instead managed by the Personnel Department, Captain Newton met with Doctor Manoukian, Managing Physician, Joanne O'Brien, Director, Medical Services Division, and Stephen Kalb, Nurse Manager, Personnel Department. Director O'Brien has reminded medical staff assigned to the jail of the requirement to have a jail staff escort, and the prohibition to conduct sick or pill call without such escort. Medical staff were reminded to request an escort when they conduct these services. In addition, all MJS jail staff have been reminded through roll call training that if a medical staff member is unaccompanied, to immediately notify a supervisor or LDO who will assign a jail staff member as an escort. The Commanding Officer of ASB and the Director of OSS concurred with this action. As such, the Chief deemed no further action is necessary.

- **CSD Observation Logs – Inmate Tracking –** The FID investigation revealed that on July 14, 2019, at approximately 0800 hours, CSD staff did not properly document the relocation of Baca from the South-D housing module into the South-B-102 single occupant segregation module. CSD Observation Logs are used to document the inmate population in housing blocks to ensure inmate accountability and that overcrowding does not occur. Captain Newton was advised of this issue and addressed the deficiency through daily roll call training, focused on the importance of documenting all inmate movement, along with the proper procedure and sequence for documenting movement. The Commanding Officer of ASB and the Director of OSS concurred with this action. As such, the Chief deemed no further action is necessary.

- **Documentation of Title 15 Safety Check –** Detention Officer Mason signed the CSD Observation Log on two occasions prior to completing the Title 15 safety checks. Detention Officers are directed to sign the CSD Observation Log upon completion of the Title 15 safety checks. Captain Newton was advised of this issue and addressed it through daily roll call training, focused on the importance of Title 15 safety checks, as well as the proper procedure and sequence for documentation of Title 15 safety checks. Additionally, Captain Newton directed all Title 15 checks to be reviewed daily by a CSD supervisor for accuracy. Further, CSD is in the process of replacing the written observation log with the Guardian Radio Frequency

[23] At the time of incident, Police Administrator G. Grube, Serial No. E8547, Commanding Officer, Administrative Services Bureau, retired, and Assistant Chief J. Peters, Serial No. 25750, Director OSS, retired, concurred with the corrective actions and discipline regarding involved personnel.

Identification (RFID) scanning system.[24] The Commanding Officer of ASB and the Director of OSS concurred with this action.[25] As such, the Chief deemed no further action is necessary.

- **Missed Title 15 Safety Checks –** Detention Officer Mason missed a mandated Title 15 safety check for July 14, at 1632 hours, as a result of being re-directed to retrieve another inmate. Captain Newton was advised of this issue and addressed the failure through divisional training, the issuance of a Notice to Correct, and the generation of a SAI. Captain Newton also directed the creation of Divisional Order No. 5 titled, "Critical Importance of Title 15 safety checks and additional auditing responsibilities," to re-emphasize the importance of safety checks in order to verify the physical wellbeing of each inmate by observing signs of life and obvious signs of distress as required by State regulations. The order also established a procedure for in-person and video monitoring along with safety check auditing by a supervisor twice per watch where feedback is provided to the officer conducting the safety check. In addition, the disposition of these checks are included in the Watch Supervisor Daily Report. An audit was provided to the Commanding Officer, Support Services Group, for each Deployment Period identifying any abnormalities. The Commanding Officer of ASB and the Director of OSS concurred with this action.[26] As such, the Chief deemed no further action is necessary.

- **Improper Inmate Escort** – When Detention Officer Mason was diverted from the July 14, 2016, 1632 hour, Title 15 safety check to escort another inmate for reasons unrelated to the ICD, Detention Officer Mason did not handcuff that felony suspect and conducted the escort alone. Detention Officer Mason's actions violated Jail Operations Manual section 2/100. Section 2/100 specifies that, "All felony inmates and any inmate, who is believed to pose a threat, should be handcuffed and escorted by two officers when being moved to or from a housing unit." Captain Newton was advised of this issue and addressed it through divisional training. In addition to training, Captain Newton directed the CSD handcuffing policy to be briefed for seven consecutive roll calls. The policy was vigorously discussed at the subsequent supervisor and OIC meetings. The Commanding Officer of ASB and the Director of OSS concurred with these actions.[27] As such, the Chief deemed no further action is necessary.

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[24] Guardian is a web based mobile inmate tracking system which includes an activity log, headcount, performs cell checks, tracks inmate movement, and provides compliance monitoring on demand by authorized CSD supervision.

[25] At the time of incident, Police Administrator Grube and Assistant Chief Peters concurred with the corrective actions.

[26] At the time of incident, Police Administrator Grube and Assistant Chief Peters concurred with the corrective actions.

[27] At the time of incident, Police Administrator Grube and Assistant Chief Peters concurred with the corrective actions.

- **Improper Radio Broadcast** – Officer Lee did not broadcast "Officer Needs Help" prior to entering Baca's cell alone and also broadcast the incorrect verbiage after entering Baca's cell. However, Jail Operations Manual section 1/260 provides an exemption to entering an occupied cell, "In an exigent, life threatening circumstance or the need to render medical aid to a lone occupant in a cell, a lone employee may enter the cell prior to the arrival of sufficient personnel." Officer Lee did broadcast "Man Down," but not until after he had already requested the opening of the cell door, entered the cell, and performed an initial assessment of Baca. Captain Newton was advised of this issue and addressed the issue through the revision of the Jail Operations Manual, section 1/260, to update the radio terminology to include the more accurate verbiage of "Man Down." A "Man Down" broadcast now not only initiates the emergency response of other jail personnel, but also summons the immediate response of Dispensary medical personnel. The Commanding Officer of ASB and the Director of OSS concurred with this action. As such, the Chief deemed no further action is necessary.

- **MJS Video Surveillance** – The FID investigation revealed that both security video systems installed at MJS were determined to note the time of recording two minutes behind actual time. Captain Newton was advised of this issue and addressed the malfunction through the initiation of a work order with the City approved vendor, wherein, the time discrepancy was resolved. The Commanding Officer of ASB and the Director of OSS concurred with this action. As such, the Chief deemed no further action is necessary.

- **Cell Inspections –** The FID investigation revealed that a cell intercom, not related to the ICD incident, was not functioning on the day of the incident. The FID investigators identified that intercom of the South-B-106 cell was not functioning on the day of the incident. Captain Newton was advised of this issue and addressed the malfunction through the initiation of a work order with the City approved vendor, wherein, the malfunction was resolved. Captain Newton also directed that Division Order No.7-2019 be reviewed for five consecutive roll calls.[28] The Commanding Officer of ASB and the Director of OSS concurred with this action. As such, the Chief deemed no further action is necessary.

- **Body Worn Video (BWV) –** Officer Heistermann had a late activation of his BWV device of approximately 29 seconds. An analysis by Central Area determined that Officer Heistermann had three prior BWV non-compliance incidents.

  Officer Haskell had a late activation of his BWV device of approximately three minutes, 22 seconds. An analysis by Central Area determined that Officer Haskell had two prior BWV non-compliance incidents.

[28] Division Order No.7-2019 states, "Prior to placing an inmate into a segregation cell, the officers shall visually inspect the cell for any contraband, general damage, vent coverage, camera obstruction or damage. Jail facilities with inmate intercoms shall perform an intercom check with their respective housing unit, ensuring the intercom operates."

With regard to the issues related to BWV for both Officers Heistermann and Haskell, they were brought to the attention of Captain Harrelson who advised that these issues were addressed with the issuance of an Employee Comment Sheet, and the generation of a SAI for each officer. The Commanding Officer of OCB and the Director of OO concurred with this action. As such, the Chief deemed no further action is necessary.

Audio/Video Recordings

- **Digital In-Car Video System (DICVS)** – Central Patrol Division police vehicles were equipped with DICVS. Officers Haskell and Heistermann's police vehicle captured Baca being placed into the rear passenger compartment and his transport to Central CPS.

- **Body Worn Video –** Central Patrol Division officers were equipped with BWV. Officers Haskell and Heistermann's BWVs captured the initial detention, arrest, and transport of Baca to Central CPS.

- **Other Video –** Central CPS was equipped with a security video system that captured footage of Baca during his time at Central CPS.

  The MJS is equipped with approximately 365 cameras that are connected to the Genetec and Verint closed circuit video systems. Each of these systems captured footage of Baca from the point Baca entered MJS until he was determined to be deceased by LAFD personnel.

Chief's Direction

- While the UOFRB determined, and the Chief concurred, that the actions of Custody Service Division personnel did not contribute to Baca's death, the course and scope of this investigation identified the need for an adjudication system with regard to In Custody Deaths. As such, the Chief directed the Director of the OSS to finalize the Categorical Use of Force, In Custody Death Adjudication Process Order, currently being drafted by Critical Incident Review Division.

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INSPECTOR GENERAL REVIEW

Inspector General Analysis

Investigation Quality

- No significant issues of concern were identified in relation to investigation quality.

Training Issues

- As noted in FID's report, Custody Services Division Sergeant I David Lopez informed investigators that he had received no formal training on jail operations prior to his assignment at MJS. FID investigators were not able to determine what training supervisory personnel received when being assigned to MJS.

  A review of Sergeant Lopez's TEAMS report showed that he was assigned to CSD, effective 3/17/2019. There is no record of any jail-related training for Sergeant Lopez, either prior to being assigned to CSD or in the months following his assignment, leading up to this incident.

- As also noted by FID, MJS is equipped with a digital system that is capable of tracking Title 15 safety checks. The system consists of card readers that are placed throughout the jail. Once an employee scans their identification card across the device, an electronic entry is made in an associated computer database known as Symmetry Global. While it appears that the system was utilized by various members of the MJS team, several members seemed to have a limited understanding of how, when, and why the system was to be used. FID investigators attempted to review written policy on the use of the Symmetry Global system, but could not identify such a policy.

Equipment Issues

- The OIG did not identify any significant issues of concern in relation to equipment beyond those already noted in the Chief's analysis.

Detention

- The OIG concurs with the Chief's analysis.

Tactical De-Escalation

- The OIG concurs with the Chief's analysis.

BWV and DICVS Policy Compliance

SERIAL	NAME	TIMELY BWV ACTIVATION	FULL 2-MINUTE BUFFER	BWV RECORDING OF ENTIRE INCIDENT	TIMELY DICVS ACTIVATION	DICVS RECORDING OF ENTIRE INCIDENT
40775	Heistermann	No	Yes	Yes	Yes	Yes
41440	Haskell	No	Yes	Yes	Yes	Yes

Additional

- The Chief's analysis of this case identified a series of concerns related to policy and procedural compliance. The OIG concurs with the Chief's analysis regarding each of the concerns identified.

Inspector General Recommendations

- The OIG concurs with the Chief's conclusion that no findings regarding Tactics, Drawing/Exhibiting of a Firearm, or Use of Force are warranted in this case. As such, no recommendations specifically with regard to findings are set forth.

MARK P. SMITH
Inspector General